Delaware Health and Social Services

Delaware Diamond State Health Plan
Section 1115 Demonstration Waiver
DRAFT
Extension Application Request

to

The Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

State of Delaware

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Table of Contents

Section I – Introduction

The Delaware Department of Health and Social Services/Division of Medicaid and Medical Assistance (DMMA) is requesting a five year extension of the current Diamond State Health Plan (DSHP) Section 1115 Demonstration waiver (DSHP 1115 Waiver). The DSHP 1115 Waiver expires on December 31, 2023.

The DSHP 1115 Waiver currently includes most individuals enrolled in Medicaid and Medicaid-expansion CHIP in Delaware and authorizes DMMA to deliver most Medicaid services through managed care. The DSHP 1115 Waiver also authorizes the DSHP Plus managed long-term services and supports program, authorizes expanded behavioral health services in the PROMISE Program, authorizes substance use disorder services in institutions for mental disease settings, and expands eligibility to certain groups, including out-of-state former foster care youth.

With the pending DSHP 1115 waiver amendment and five-year waiver extension, DMMA will continue to build upon Medicaid's success with managed care and value-based payment, improve upon maternal and child health outcomes, address health inequities, expand access to substance use disorder services and invest in additional supports for individuals and families who rely on long term services and supports.

Section II – DSHP 1115 Waiver Program Background, Description, Goals and Objectives

Delaware's DSHP 1115 Demonstration Waiver (DSHP 1115 Waiver) was initially approved in 1995, and implemented on January 1, 1996. The original goal of DSHP 1115 Waiver was to improve the health status of low-income Delawareans by expanding access to healthcare to more individuals throughout the State; creating and maintaining a managed care delivery system with an emphasis on primary care; and controlling the growth of healthcare expenditures for the Medicaid population.

Delaware has been successful in achieving these early objectives. The DSHP 1115 Waiver was designed to mandatorily enroll eligible Medicaid recipients into managed care organizations (MCOs) and create cost efficiencies in the Medicaid program that could be used to expand coverage. Delaware achieved its objective of implementation of mandatory managed care focused on primary care in 1996 and invested the resulting waiver savings in Delaware's Medicaid eligibility coverage expansion to uninsured adults up to 100% of the federal poverty level. Long before Medicaid expansion under the Affordable Care Act, Delaware was a pioneer in coverage expansion for individuals who would otherwise not be eligible for Medicaid. Delaware built upon this success with the eventual expansion of coverage for family planning services, leading up to Medicaid expansion under the Affordable Care Act in 2014. The demonstration was previously renewed on June 29, 2000, December 12, 2003, December 21, 2006, January 31, 2011, September 30, 2013, and August 1, 2019 and has remained budget neutral to the federal government. Over the last 27 years, Delaware has demonstrated that the DSHP 1115 Waiver can provide quality physical health, behavioral health, and long-term services and supports through a private and public sector cooperation to a greater number of uninsured or underinsured individuals, and at a lesser or comparable cost than the projected fee-for-service program costs for the Medicaid eligible population. For additional detail on Delaware's successes in meeting its goals and

objectives as well as opportunities for improvement, please see the Interim Evaluation summary results in Section VIII and the full evaluation reports on DMMA's website (https://dhss.delaware.gov/dhss/dmma/medicaid.html) as part of this draft application. Attachment B is reserved for the interim evaluation reports in the final application to CMS.

In 2012, the DSHP 1115 Waiver was amended to add Diamond State Health Plan Plus (DSHP-Plus), Delaware's managed long-term services and supports (MLTSS) program, to help rebalance Delaware's long-term services and supports system in favor of home and community-based services (HCBS). Individuals enrolled in DSHP Plus include: (1) individuals receiving care at nursing facilities (NF) other than intermediate care facilities for the mentally retarded (ICF/MR); (2) children in pediatric nursing facilities; (3) individuals who receive benefits from both Medicaid and Medicare (dual eligibles); and (4) workers with disabilities who buy-in for coverage. This amendment also added eligibility for the following new demonstration populations: (1) individuals who would previously have been enrolled through the 1915(c) home and community based services (HCBS) waiver program for the Elderly and Disabled – including those receiving services under the Money Follows the Person demonstration; (2) individuals who would previously have been enrolled though the 1915(c) HCBS waiver for Individuals with Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS) Related Diseases; (3) individuals residing in NF who no longer meet the current medical necessity criteria for NF services; and (4) adults and children with incomes below 250 percent of the Supplemental Security Income Federal Benefit Rate who are at risk for institutionalization. Additionally, this amendment expanded HCBS to include: (1) cost-effective and medically necessary home modifications; (2) chore services; and (3) home delivered meals. As noted in the Interim Evaluation results, Delaware has been successful in our efforts to rebalance our LTSS system in greater favor of HCBS. For example, the proportion of spending between HCBS and institutional care changed from a mix of 25 percent/75 percent in CY 2018 to 35 percent/65 percent in CY 2021. The per member per month (PMPM) expenditures for HCBS among DSHP Plus members also increased 39 percent while the PMPM expenditures for institutional care decreased 16 percent.

In 2013, the DSHP 1115 Waiver was renewed and amended to provide authority to extend the low income adult demonstration population to individuals with incomes up to 100 percent of the FPL until December 31, 2013. After that date, the demonstration population was not necessary because it was included under the approved state plan as the new adult eligibility group authorized under the Affordable Care Act (ACA). The new adult group, for individuals with incomes up to 133 percent of the FPL, receive medical assistance through enrollment in MCOs pursuant to this DSHP 1115 Waiver.

The DSHP 1115 Waiver was later amended at the end of 2014 to add coverage in 2015 for enhanced behavioral health services and supports for targeted Medicaid beneficiaries through a voluntary program called Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE). PROMISE enrollees include Medicaid beneficiaries who have a severe and persistent mental illness (SPMI) and/or a substance use disorder (SUD) and require HCBS to live and work in integrated settings. As noted in the Interim Evaluation results, the creation of PROMISE has begun expanding capacity for increased access to behavioral health HCBS through expanded enrollment and provider networks, but PROMISE has not yet achieved the program's full potential.

A waiver amendment was approved in December 2017 to add coverage for out-of-state former foster care youth. The number of out-of-state former foster care youth was too small for the Interim Evaluation to observe statistically significant results.

On August 1, 2019, the DSHP 1115 waiver was extended for an additional five years and an amendment approved to provide DMMA with authority to provide high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD). Delaware has not yet met all of the desired outcomes outright but still saw many positive impacts due to the demonstration. As noted in the Interim Evaluation, the PHE likely had a confounding effect in enabling Delaware to fully meet these aims during the demonstration period.

Since 2020, DMMA has amended the DSHP 1115 Waiver for the addition of adult dental services to the DSHP managed care delivery system and secured COVID-19 demonstration amendment authorities focused on HCBS services (e.g., provider retainer payments, expanded home-delivered meals) to address the COVID-19 Public Health Emergency (PHE). DMMA also has an amendment pending with CMS to add home-visiting coverage, a second home-delivered HCBS meal, pediatric respite, a self-directed option for parents of children receiving personal care services, and nursing facility transition services.

Delaware's goal and objectives in operating the DSHP 1115 Waiver into the future continue to be to improve the health status of low-income Delawareans by:

1. Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to home and community-based services (HCBS);
2. Rebalancing Delaware's LTC system in favor of HCBS;
3. Promoting early intervention for individuals with, or at-risk, for having, LTC needs;
4. Increasing coordination of care and supports;
5. Expanding consumer choices;
6. Improving the quality of health services, including LTC services, delivered to all Delawareans;
7. Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTSS services where appropriate;
8. Expanding coverage to additional low-income Delawareans;
9. Improving overall health status and quality of life of individuals enrolled in PROMISE;
10. Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population;
11. Increasing enrollee access to and utilization of appropriate SUD treatment services and decrease use of medically inappropriate and avoidable high-cost emergency and hospital services;
12. Increasing access to dental services, including follow-up care and care for adults with diabetes, and decrease use of emergency department visits for non-traumatic conditions;
13. Improving maternal and infant health outcomes and health disparities (new for renewal period).

Section III – Summary of the Current DSHP 1115 Demonstration

Eligibility – Most Medicaid and Medicaid-expansion CHIP state plan eligibility groups are enrolled in DSHP. The groups described in Table A below are Medicaid eligible, but excluded from enrollment in DSHP.

Table A. DSHP Eligibility Exclusions

Current DSHP Eligibility Exclusions
Individuals participating in a PACE Program
Qualified Medicare Beneficiaries (QMBs)
Specified Low Income Medicare Beneficiary (SLMB)
Qualifying Individuals (QI)
Qualified and Disabled Working Individuals
Individuals in a hospital for 30 consecutive days (acute care)
Presumptive Breast and Cervical Cancer for Uninsured Women
Breast and Cervical Cancer Program for women
Institutionalized individuals in an ICF/MR facility

DSHP also extends eligibility to non-state plan eligibility groups for their receipt of LTSS through DSHP-Plus and adds coverage for out-of-state former foster care youth. These groups are described in detail as "Demonstration Population Expenditures" in the current approved 1115 Demonstration.

Table B. Demonstration-Eligible Groups

Current DSHP Demonstration-Eligible Groups
217-Like Elderly and Disabled Home and Community Based Services (HCBS) Group: Aged and/or disabled categorically needy individuals over age 18 who meet the Nursing Facility LOC criteria in place at the time of HCBS enrollment and receive HCBS as an alternative (formerly served through an Elderly & Physically Disabled 1915c Waiver)
217-Like HIV/AIDS HCBS Group: Individuals with a diagnosis of AIDs or HIV over age 1 who meet the Hospital LOC criteria and who receive HCBS as an alternative (formerly served through an AIDS/HIV 1915c Waiver)
Aged and/or disabled individuals over age 18, who do not meet a NF LOC, but who, in the absence of HCBS, are "at-risk" of institutionalization and meet the "at-risk" for NF LOC criteria in place at the time of enrollment and who need/are receiving HCBS
TEFRA-Like Children (Katie Beckett) using the "at-risk of NF" LOC criteria in place at time of enrollment

Nursing facility residents, who do not currently meet the NF LOC criteria, but continue to meet the NF level of care criteria in place at the time of admission/enrollment.
Individuals receiving HCBS for the disabled and elderly, who do not meet the NF LOC criteria, but continue to meet the LOC criteria in place at the time of enrollment, including HCBS furnished under a terminated 1915(c) waiver.
Disabled children with incomes at or below 250 percent of the SSI, who do not meet the NF or hospital LOC criteria, but continue to meet the LOC criteria in place at the time of their enrollment.

DMMA is proposing to continue the current state plan and 1115 waiver eligibility groups for the DSHP extension.

Benefits – Individuals enrolled in the DSHP 1115 Demonstration receive most Medicaid and CHIP State Plan benefits through the DSHP 1115 Demonstration delivery system. Individuals eligible for DSHP-Plus receive comprehensive, integrated LTSS and individuals eligible for PROMISE receive enhanced behavioral health services in order to live and work in community-based integrated settings. DSHP also provides coverage for high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as IMDs.

DMMA is proposing to continue the current approved state plan and 1115 waiver benefits through the DSHP extension and add new benefit as described in Section IV.

Delivery System – DSHP and DSHP-Plus benefits are delivered through mandatory enrollment in MCOs. A limited number of benefits, such as children's dental and non-emergency transportation, are currently delivered through fee-for-service (FFS). DSHP enrollees receive these benefits through Medicaid fee-for-service, not through the DSHP 1115 Waiver. PROMISE benefits are delivered through the FFS PROMISE program administered through the Division of Substance Abuse and Mental Health (DSAMH).

Table C. FFS Benefits Excluded from the DSHP 1115 Waiver

FFS Benefits (Not currently provided through the DSHP 1115 Waiver)
Dental services for children
NEMT Transportation broker services, except for emergency ambulance transportation
Day services authorized by the Division of Developmental Disabilities Services
Medically necessary behavioral health services for children in excess of MCO plan benefit coverage, which is 30 visits for children
Prescribed pediatric extended care
Targeted case management (TCM)

DMMA is proposing to continue the managed care and FFS delivery systems described in the current DSHP waiver, with the exception of children's dental services. As described in Section IV, DMMA is proposing to include children's dental services through the DSHP MCOs.

Cost Sharing – Cost-sharing does not differ from the approved Medicaid and CHIP State Plans and DMMA is not proposing cost-sharing under the DSHP 1115 Waiver.

Section IV – Changes Under the Demonstration Extension

A. July 2022 Pending Amendment

DMMA has proposed five changes to the DSHP 1115 Waiver pending in an amendment currently under review by CMS for an effective date of January 1, 2023. The changes in this amendment include:

1. Coverage of two models of evidenced-based home visiting for pregnant women and children.

   DMMA has requested authority to include access to home visiting to pregnant women and children through the Nurse Family Partnership (children up to the age of two) and Healthy Families Delaware (up through the child's third birthday) evidenced-based home visiting programs. With this new benefit, DMMA seeks to begin to address racial disparities within the maternal health crisis.

2. Permanent coverage for a second home-delivered meal for members receiving HCBS in DSHP Plus.

   In response to the COVID-19 PHE and the increased risk of food insecurity in our Medicaid DSHP Plus members receiving HCBS, DMMA sought temporary authority through an Appendix K amendment to the DSHP 1115 waiver so that DSHP Plus HCBS members could receive a second home-delivered meal per day. This additional meal has been successful in supporting members to remain in their homes, contributed to Delaware's goals of increasing supports for members needing LTSS and promoted early intervention for individuals with long-term care needs. DMMA has requested authority in the DSHP 1115 Waiver to provide up to two home-delivered meals per day as part of the permanent DSHP Plus benefit package.

3. Coverage of a pediatric respite benefit as an American Rescue Plan Act (ARP) Section 9817 HCBS Spending Plan initiative.

   Families with children with complex medical conditions (CMC), severe emotional disorders and dual diagnoses of MH/IDD face specific challenges in supporting their child within the family unit. In response to a cross section of stakeholders who provided feedback during the American Rescue Plan Act of 2021 Section 9817 HCBS Spending Plan listening sessions, DMMA has proposed to add a Medicaid-funded respite service for caregivers of children with CMC, severe emotional disorders and dual diagnoses of behavioral health/IDD.

4. Coverage of a self-directed option for parents on behalf of children receiving state plan personal care services.

In response to extensive feedback during Delaware's HCBS Spending Plan listening sessions as well as during DMMA's work with stakeholders, including parents of children with CMC, DMMA has identified the need to address gaps in care that parents and families are experiencing as a result of the direct service provider (DSP) workforce shortage. To address this shortage and empower families to identify and provide care that meets the needs of their children, DMMA has requested authority to allow parents to self-direct the State Plan personal care (attendant care) services minor children receive today. This self-directed option will give families the flexibility to hire, for example, a neighbor, friend, or family member, including a legally responsible family member as the service provider, as long as the individual meets all employee qualifications as verified by the DSHP MCO. This option will also support the DSHP MCOs in maintaining appropriate and timely access to care.

5. Coverage of Delaware's Nursing Home Transition Program (formerly Money Follows the Person Demonstration) in the DSHP 1115 waiver.

   DMMA initially received federal funding for our Money Follows the Person program, Finding A Way Home, in 2007. In 2017, when MFP funding was exhausted, Finding A Way Home became an integral component of the nursing facility transition services under the DSHP Plus managed long-term services and supports MCO contracts. Although MFP no longer funded the transitions after 2017, these transitions have continued as DMMA and our partner MCOs sustained the MFP activities that worked well and used the lessons learned from MFP to improve upon policies for effective transitions. In CYs 2020-2021, DMMA and DSHP MCOs transitioned 230 individuals. This waiver amendment incorporates these services into the DSHP Plus waiver benefits.

Additional description of these changes can be found in the pending amendment available on the DMMA website at: https://dhss.delaware.gov/dhss/dmma/medicaid.html

DMMA is proposing to include these changes, once approved by CMS, in the waiver extension.

B. New Changes Proposed for the DSHP Extension

DMMA is proposing four new changes in the extension period:

1. Expanding access by providing three-months of retroactive eligibility to all Medicaid enrollees.
2. Piloting Medicaid coverage of Delaware's Food Box Initiative for postpartum members.
3. Adding Medicaid coverage of contingency management services for certain members with a stimulant use disorder and/or opioid use disorder.
4. Adding children's dental services under the DSHP 1115 managed care delivery model.

B.1. Expanding Access by Providing Three-Months of Retroactive Eligibility to DSHP 1115 Waiver Enrollees

Proposal: DMMA will not renew the current DSHP waiver of retroactive eligibility.

Objective: DMMA will terminate this waiver authority to support our goal of expanding access to coverage, including coverage for those who need immediate care while applying for Medicaid.

Background and Details*:* Under the current DSHP 1115 waiver of Section 1902(a)(34) of the Social Security Act, retroactive eligibility is only provided to institutionalized individuals in nursing facilities, individuals in the Ticket to Work Basic Group, pregnant women and children under the age of 19 in all applicable eligibility groups for three months prior to the application month. Other eligibility groups, including the Adult Expansion Group, are not eligible for retroactive eligibility under the terms of the DSHP 1115 Waiver. This waiver authority was initially granted by CMS as part of Delaware's early expansion of Medicaid (prior to the Affordable Care Act), and is no longer necessary. Effective no later than January 1, 2024, with the expiration of the current DSHP 1115 waiver, DMMA will extend retroactive eligibility to all eligible DSHP and DSHP-Plus participants three months prior to the date that an application for medical assistance is made. DMMA's timeline for terminating this authority is based on our operational experience with adding retroactive eligibility for pregnant members and children in 2019/2020 and the anticipated efforts related to "unwinding" the COVID-19 PHE in 2023.

Waiver Impact: None. Members months associated with retroactive eligibility will be covered outside of the DSHP 1115 Waiver in Medicaid FFS.

B.2. Piloting Medicaid coverage of Delaware's Food Box Initiative for postpartum members

Proposal: DMMA proposes to pilot a Medicaid Food Box Initiative to provide home-delivered food and diapers to postpartum members enrolled in the DSHP 1115 Waiver.

Objective and Expected Outcome: The objective of the Food Box Initiative is to address food insecurity and diaper needs as health-related social needs to improve maternal and infant heath and narrow health disparities. The proposed demonstration would allow DMMA to use Medicaid funds to expand our current state-funded pilot to provide home-delivered food and diapers to postpartum members, reaching low-income postpartum members with disproportionately high rates of food insecurity and inequitable adverse maternal and birth outcomes.

Background and Details: Food insecurity is an important health-related social need, associated with poor health and recognized as a driving force of health inequities. This is particularly true for low-income mothers and their infants during the post-partum period. Compared to their food-secure peers, food insecure mothers are over twice as likely to report mental health problems during the

post-partum period, such as stress, depression and anxiety, all while caring for a newborn.[1] Food insecure mothers also experience decreased rates of breastfeeding. Breastfeeding[2] can help protect babies against short- and long-term illnesses and disease, such as asthma, obesity, and diabetes. It can help babies develop a strong immune system and protect them from illnesses, such as ear infections and stomach bugs. Breastfeeding can reduce the mother's risk of breast and ovarian cancer, diabetes, and high blood pressure. For the health of mothers and their infants, the postpartum period is a critical time to support household food security and diaper need, especially for families with limited or strained economic resources.

Food insecurity is impacted by intersecting social determinants of health, such as food access. There is significant racial inequity in the distribution of food in the United States. Access to local supermarkets is associated with increased intake of fruit and vegetables. In predominantly Black neighborhoods, the availability of supermarkets is only half that of White neighborhoods, and in predominantly Hispanic neighborhoods, it is even lower. A lack of access to healthy food choices and an abundance of access to cheap, unhealthy food disproportionately predominates the landscape of low-income and minority communities. Food access is impacted by the distance and time required to travel to buy healthy food, and, for many, the cost of transportation can be prohibitive.

In recognition of the impact of food insecurity on health outcomes and health disparities and the impact of the COVID-19 PHE on our members, DMMA began piloting a Postpartum Food Box Delivery program in February 2021, in partnership with the Food Bank of Delaware for food box supplies, our NEMT broker for transportation, and our DSHP MCOs for care coordination. The program was first piloted with state-only funds for the food boxes for our DSHP members who delivered via caesarean section and then expanded to all of our DSHP postpartum members in July 2021. Our DSHP postpartum members receive one shelf-stable food box, up to two boxes of diapers, and one pack of wipes per week for up to 8 weeks postpartum. As of October 2022 we have delivered almost 24,000 boxes of food, 35,000 boxes of diapers, and 17,000 boxes of wipes.

DMMA has received an overwhelmingly positive response from our members and partners. The program has also shown initial benefits in member health outcomes, including:

- Postpartum members in program (Feb 2021- March 2022): 1455 members; **85% attended a postpartum visit**
- Infants in the program (Feb 2021- March 2022): 1466 infants; **95% had at least one well child visit**

[1] https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0645
[2] https://www.cdc.gov/nccdphp/dnpao/features/breastfeeding-benefits/index.html

There are significant health disparities with our maternal/infant health outcomes, with Black infant mortality two to three times higher than White infants. This program is helping to address those health disparities. To date:

- **57% of members** who received deliveries were Black or Hispanic
- More than **40% of food box deliveries were to "high risk" zip codes in Delaware**, based on Delaware Division of Public Health data

DMMA is proposing to continue this Food Box Initiative, including food box delivery, as a Medicaid pilot in the DSHP 1115 Waiver extension period. This would allow DMMA to use Medicaid funds to continue the Food Box Initiative, including the food box supplies and transportation, and further evaluate its sustained positive impact on low-income families with disproportionately high rates of food insecurity and diaper needs and inequitable adverse maternal and birth outcomes.

Waiver Impact: Approximately 8,841 members and $8.29 million over five years.

B.3. Contingency Management

Proposal: DMMA is seeking authority to provide contingency management services for Medicaid members who are: (1) age 18 and over with a stimulant use disorder diagnosis and (2) age 18 and over, who are pregnant or up to 12 months postpartum, with an opioid use disorder diagnosis. Contingency management is an evidence-based practice that allows individuals to earn small motivational incentives for meeting treatment goals, such as negative urine drug tests or medication adherence.

Objective and Expected Outcome: The objectives of contingency management services are to expand SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder to help address the rise in fatal drug overdoses throughout Delaware. DMMA also expects this initiative to improve health outcomes and address health disparities.

Background and Details: According to the latest data from the Centers for Disease Control and Prevention, Delaware had the 3rd highest rate of drug overdoses in the country in 2020, at 47.3 deaths per 100,000 people.[3] Similar to many states, opioids and stimulants are the primary substances of recent concern. For example, in its annual report for 2021, the Delaware Division of Forensic Science (DFS) reported 515 overdose deaths in the state, an increase of 15% over the number of overdose deaths in 2020 (447).[4] Of the 515 overdose deaths reported in 2021, DFS reported that 425 deaths (82.5%) involved fentanyl, 68 deaths involved heroin (13.2%), and 221 (42.9%) involved cocaine. Deaths from methamphetamine are also on the rise, increasing from 1.9% of all postmortem cases investigated by DFS in 2017, to 8.4% in 2021.[5] Additionally, a special population of interest for

[3] https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm
[4] https://forensics.delaware.gov/resources/contentFolder/pdfs/2021 DFS Annual Report.pdf?cache=1654718076322
[5] https://forensics.delaware.gov/resources/contentFolder/pdfs/2021 DFS Annual Report.pdf?cache=1654718076322

Delaware is pregnant and postpartum people with substance use disorders (SUD). According to the latest data from the Centers for Medicare & Medicaid Services (CMS), Delaware had the 8th highest rate of SUD in the United States among Medicaid beneficiaries in the pregnant enrollment category,[6] and the 3rd highest rate of neonatal abstinence syndrome.[7]

Contingency management is the only treatment that has demonstrated robust outcomes for individuals with stimulant use disorder, including reduction or cessation of drug use and longer retention in treatment. Further, contingency management has also demonstrated a wide range of positive outcomes for individuals with an opioid use disorder,[8] including more days of abstinence from opioids, increased retention in SUD treatment, and increased adherence to medications used to treat opioid use disorder. Research also shows that contingency management is particularly well-suited for use among pregnant individuals, given the limited timeframe of pregnancy, and the potential to benefit both maternal and infant health. For example, research has shown that contingency management can both reduce illicit substance use during pregnancy[9] and reduce hospital days for newborns.[10]

DMMA plans to implement two unique contingency management programs: (1) a program for Medicaid members aged 18 and over with a stimulant use disorder diagnosis; and (2) a program for Medicaid members aged 18 and over, who are pregnant or up to 12 months postpartum, with an opioid use disorder diagnosis. See Table 1 below for a summary of the Medicaid members eligible to participate in each program, along with the core treatment goals incentivized. Under this demonstration, DMMA proposes to allow for a maximum of $599 in incentives for each eligible member participating in a contingency management program each year, with the average duration of the contingency management program expected to be between 24 to 64 weeks, depending on the population of focus (see Table 1). DMMA selected $599 as the maximum incentive amount because it is the most an individual can receive without paying taxes on these funds. Incentives would be provided in the form of low-denomination gift cards (which could not be used to purchase cannabis, tobacco, alcohol, or lottery tickets).

[6] https://www.medicaid.gov/medicaid/data-systems/downloads/2019-sud-data-book.pdf
[7] https://data.medicaid.gov/dataset/0563d88c-8fe5-42a8-9d69-f67fd21c0e91
[8] https://jamanetwork.com/journals/jamapsychiatry/article-abstract/205837 https://psycnet.apa.org/record/2013-10259-001 https://www.tandfonline.com/doi/full/10.1080/07853890.2022.2068805
[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5714659/#R32
[10] https://pubmed.ncbi.nlm.nih.gov/25835053/

Table 1: Proposed Contingency Management Programs under DSHP

Program name	Population	Eligible Providers	Core Treatment Goal (incentivized outcome)	Expected Timeframe
Contingency Management Program for Stimulant Use Disorder (CM-StUD)	Individuals ages 18 and older who are diagnosed with stimulant use disorder (e.g., methamphetamine, cocaine, similar drugs), based on a completed SUD assessment	Outpatient SUD providers	Negative drug tests[11]	24 weeks
Contingency Management Program for Pregnant and Postpartum People with Opioid Use Disorder (CM-PPP-OUD)	Individuals ages 18 and older, who are pregnant and/or up to 12 months postpartum, with a diagnosed opioid use disorder, based on a completed SUD assessment	Opioid treatment programs (OTPs), OB-GYNs, primary care providers, outpatient SUD providers	Medication adherence (i.e., adherence to medications used to treat opioid disorder, such as methadone or buprenorphine)	64 weeks

The contingency management program will be open to eligible providers across the state, with DMMA using a request for proposal or similar process to ensure participating providers are qualified and meet minimum expectations (this would be in addition to a quality assurance plan, as outlined below). MCOs will be responsible for contracting with qualified, enrolled contingency management providers.

Qualified providers will have the ability to bill a new service code for "contingency management coordination services" (e.g., providing instructions to clients regarding contingency management processes and protocols; distribution of urine drug tests; monitoring drug test results, etc.). DMMA proposes distributing funds for contingency management incentives through the DSHP MCOs, using a directed payment as allowed under 42 CFR 438.6(c). Therefore, incentive funds would flow from the

[11]Although negative drugs tests will be the core treatment goal for the CM-StUD program, DMMA views this as just one tool in a more comprehensive treatment approach. Providers will be encouraged to continue to use a harm reduction approach to treatment overall, in part by not focusing solely on abstinence as a sign of progress toward recovery.

DMMA to the MCOs, to contracted qualified providers, to eligible beneficiaries participating in contingency management programs who meet identified treatment goals.

To mitigate the risk of fraud and abuse while promoting this evidence-based practice, DMMA, in partnership with its contracted MCOs, will implement a quality assurance plan that ensures: 1) specialized training for those who implement, administer, and supervise contingency management interventions; 2) adherence to stringent documentation requirements at the program-level and in the patient's medical record; and 3) adherence to requirements that the incentives are not cash, are only disbursed upon achievement of the specific target behaviors, and are recommended by a qualified, treating clinician.

Waiver Impact: Approximately 800 members and $1.54 million over five years.

B.4. Expanding the DSHP 1115 Waiver to Include Children's Dental Services in Managed Care

Proposal: Effective January 1, 2024, DMMA is proposing to include children's dental services in the DSHP 1115 Waiver managed care delivery system.

Objective and Expected Outcome: The objective of including children's dental services in DSHP managed care is to ensure access to high-quality dental care for children and support a coordinated and integrated delivery system. DMMA expects dental managed care for children will result in a positive (or no negative) impact on child dental access, health outcomes and parent/caretaker satisfaction.

Background and Details: Managed care through the DSHP MCOs is the foundation of Delaware's Medicaid delivery system. Currently, children's dental services are one of only a few services excluded ("carved out") from the DSHP managed care delivery system and are instead provide on a fee-for-service basis. The DSHP MCOs are responsible for coordinating care for members between FFS and managed care, but are not responsible for ensuring that children enrolled in Medicaid have access to high-quality dental care. DMMA is proposing to carve these services in to the DSHP managed care delivery system after robust stakeholder engagement and planning. As DMMA did in 2019 with the development of the adult dental benefit, beginning in 2023, DMMA will engage stakeholders, including families and providers, throughout the process of developing the plans for implementation, continuity of care, member communication, referral and follow-up care, payment, incentives, provider education, and MCO performance standards and oversight. DMMA expects the DSHP MCOs to maintain or increase access and family satisfaction with Medicaid dental services over the demonstration.

Waiver Impact: Beginning in CY 2024, approximately 114,000 Medicaid-enrolled children will begin receiving their dental services through MCOs under the DSHP 1115 Waiver. These expenditures are currently excluded from the DSHP 1115 Waiver. Dental managed care will shift approximately $327 million in expenditures over five years from FFS to the DSHP 1115 Waiver.

Section V – Waiver and Expenditure Authorities

DMMA is requesting to continue all current approved and pending waiver and expenditure authorities, with the exception of the waiver of retroactive eligibility. DMMA is not requesting to renew the current waiver of retroactive eligibility.

Table 1. Requested Waiver Authorities

	Waiver Authority	Use for Waiver/Expenditure Authority	Current/Expanded/ New/Terminated Waiver Authority Request
1.	Amount, Duration, and Scope of Services Section 1902(a)(10)(B) and 1902(a)(17)	To the extent necessary to enable Delaware to offer a different benefit package to DSHP and DSHP-Plus participants than is being offered to the traditional Medicaid population. To the extent necessary to enable Delaware to provide additional services to enrollees in the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) Program. The waiver request is being expanded to include the extension changes described in Section IV: (1) To the extent necessary to enable Delaware to provide additional services to enrollees participating in the Food Box Pilot initiative for postpartum members as described in Section IV of this application. (2) To the extent necessary to enable Delaware to provide contingency management services not otherwise available to all members in the same eligibility group but based on individual assessments of need according to criteria described in Section IV this application.	Current/Expanded

2.	Provision of Medical Assistance Section 1902(a)(8) and 1902(a)(10)	To the extent necessary to enable Delaware to limit the provision of medical assistance (and treatment as eligible) for individuals described in the eligibility group under section 1902(a)(10)(A)(ii)(XX) of the Act and the Medicaid State Plan to only former foster care youth who are under 26 years of age, were in foster care under the responsibility of another state or tribe on the date of attaining 18 years of age (or such higher age as the state has elected), were enrolled in Medicaid on that date, and now residents in Delaware applying for Medicaid.	Current
3.	Freedom of Choice Section 1902(a)(23)(A)	To the extent necessary to enable Delaware to restrict freedom-of-choice of provider through the use of mandatory enrollment into managed care plans for DSHP and DSHP- Plus participants. To the extent necessary to enable the state to use selective contracted fee-for-service (FFS) providers, including for Home and Community Based Services (HCBS) and a transportation broker for non- medical transportation. No waiver of freedom of choice is requested for family planning providers. The waiver request is being expanded to include the extension changes described in Section IV: To enable Delaware to restrict freedom of choice of provider for the Food Box Pilot Initiative, contingency management services, and children's dental services through the use of mandatory enrollment in MCOs.	Current/Expanded
3.	Retroactive Eligibility Section 1902(a)(34)	To the extent necessary to enable Delaware to not extend eligibility to DSHP and DSHP- Plus participants prior to the date that an application for assistance is made, with the exception of institutionalized individuals in nursing facilities and qualified disabled working individuals (QDWIs), as outlined in Table A of the STCs. The waiver of retroactive eligibility does not apply to pregnant women (including during the 60-day postpartum period beginning on the last day of the pregnancy), infants under age 1, or individuals under age 19.	Terminate

4.	Self-Direction of Care Section 1902(a)(32)	To the extent necessary to enable Delaware to permit parents (on behalf of children up to age 21) to self-direct state plan personal care services.	New (Pending Amendment)

Table 2. Requested Expenditure Authorities

	Use for Expenditure Authority	Currently/Expanded/ New Expenditure Authority Request
1.	**217-Like Elderly and Disabled Home and Community Based Services (HCBS) Group:** Expenditures for medical assistance for disabled individuals over age 18 who meet the Nursing Facility (NF) level of care (LOC) criteria and who would otherwise be Medicaid-eligible if the state had elected the group described in section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR 435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if enrolled and receiving services under a 1915(c) HCBS waiver program	Current
2.	**217-Like HIV/AIDS HCBS Group:** Expenditures for medical assistance for individuals over age 1, who have a diagnosis of AIDS or HIV, who meet the hospital LOC criteria, and who would otherwise be Medicaid-eligible if the state had elected the eligibility group described in section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR 435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, and they were enrolled and receiving services under a 1915(c) HCBS waiver program.	Current
3.	**"At-risk" for Nursing Facility Group:** Expenditures for medical assistance for disabled individuals over age 18 with incomes at or below 250 percent of the Supplemental Security Income (SSI) Federal Benefit Rate who do not meet the NF LOC, but are "at-risk" for institutionalization.	Current
4.	**TEFRA-Like Group:** Expenditures for medical assistance for disabled children under age 18 with incomes at or below 250 percent of the SSI who do not meet the NF LOC, but are "at-risk" of institutionalization absent the provision of DSHP services. The state will use financial institutional eligibility rules for individuals who would not be eligible in the community because of community deeming rules (in the same manner that would be used if the group were eligible under the state plan.	Current

	Use for Expenditure Authority	Currently/Expanded/ New Expenditure Authority Request
5.	**Continuing Receipt of Nursing Facility Care:** Expenditures for medical assistance for nursing facility residents, who do not currently meet the NF LOC criteria, but continue to meet the NF level of care criteria in place at the time of admission/enrollment.	Current
6.	**Continuing Receipt of Home and Community-Based Services:** Expenditures for medical assistance for individuals receiving HCBS for the disabled and elderly, who do not meet the NF LOC criteria, but continue to meet the LOC criteria in place at the time of enrollment, including HCBS furnished under a terminated 1915(c) waiver.	Current
7.	**Continuing Receipt of Medicaid State Plan Services:** Expenditures for medical assistance for disabled children with incomes at or below 250 percent of the SSI, who do not meet the NF or hospital LOC criteria, but continue to meet the LOC criteria in place at the time of their enrollment.	Current
8.	**PROMISE Services:** Expenditures for behavioral health services beyond the services described in the approved state plan for otherwise eligible individuals enrolled in the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) program.	Current
9.	**HCBS for Medicaid State Plan Eligibles**: Expenditures to provide HCBS not included in the Medicaid State Plan to individuals who are eligible for Medicaid as described in the STCs. This request includes expenditures for home-delivered meals and pediatric respite benefits that are under review by CMS in a waiver amendment.	Current/Expanded (Pending Amendment)
10.	**Residential and Inpatient Treatment for Individuals with a Substance Use Disorder (SUD):** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an Institution for Mental Diseases (IMD).	Current
11.	**Home visiting for Medicaid eligible pregnant women and children under the age of three:** Expenditures to provide evidenced-based home visiting to Medicaid eligible pregnant women and children.	New (Pending Amendment)

	Use for Expenditure Authority	Currently/Expanded/ New Expenditure Authority Request
12.	**Self-directed personal care/attendant care for children:** Expenditures to provide self-directed personal care/attendant care for children receiving state plan personal care services.	New (Pending Amendment)
13.	**Nursing facility transition services:** Expenditures to provide coverage of short-term nursing facility transition services to support a DSHP Plus member's transition from a nursing facility to an HCBS setting.	New (Pending Amendment)
14.	**Post-partum Food Box Initiative:** Expenditures to provide coverage of food boxes, including transportation to members, for members up to 12 weeks postpartum.	New
15.	**Contingency management services:** Expenditures to provide contingency management services to eligible individuals with a qualifying stimulant use and/or opioid use disorder.	New

Section VI – Summaries of Quality and Monitoring Reports

DMMA regularly monitors the DSHP 1115 Waiver and MCOs for quality assurance and improvement to ensure progress towards the demonstration's goals and objectives and compliance with CMS rules for Medicaid MCOs. This includes, but is not limited to, Implementation of the DMMA Quality Strategy, External Quality Review Organization (EQRO) results and recommendations, and the quarterly and annual reports DMMA submits to CMS. Below is a summary of the most recent activities and information from Delaware's external quality review organization (EQRO) reports and ongoing quality assurance and monitoring activity.

A. Summary of External Quality Review Results 2019-2021

2019 Annual External Quality Review Reporting

During 2019, Delaware's EQRO (Mercer) completed a comprehensive compliance review of the two DSHP MCOs that encompassed the three mandatory activities, compliance review, validation of Performance Measures (PMs) and validation of Performance Improvement Projects (PIPs) for both MCOs. The EQRO identified a number of strengths and opportunities for improvement for both MCOs. The annual technical report was submitted to CMS on April 30, 2020.

The EQRO also completed a comprehensive ISCA. The Performance Measure Reporting ISCA items for both MCOs resulted in 13 of the 13 items receiving a score of "Met." There were no concerns identified

with any processes for integrating Medicaid claims, encounter, membership, provider, subcontractor and other data to calculate Medicaid PMs.

In addition to completion of mandatory activities, the EQRO conducted the following activities:

- Encounter Data Validation (EDV) of Medicaid encounter data received from the two MCOs. Overall, the EQRO found the MCOs had appropriate processes and systems for managing their encounter data submissions, and made extra effort to work with DXC to diagnose and resolve encounter related issues.

- Readiness review for managed care enrollment of Individuals with Intellectual/Developmental Disabilities (I/DD) enrolled in the 1915(c) Lifespan Waiver. After the EQRO's initial review, the MCOs submitted follow up materials which were evaluated in an iterative process and technical assistance was provided when needed. A post go-live onsite follow up review was scheduled for 2020 to focus on best practices, lessons learned and prior authorization practices subsequent to the continuity of care period.

- Technical assistance with Case Management (CM) and Care Coordination (CC) Performance Measure reporting. DMMA required the MCOs to report quarterly on Clinical Care Coordination (CCC), resource coordination and CM as one path to ensure appropriate care for DSHP and DSHP Plus members. Throughout 2018, the EQRO met with DMMA to discuss challenges with gathering accurate and reliable data on the required CCC PMs. Challenges included the MCO data submissions in different formats and programs (i.e. Word, Excel, PDF), inconsistency in the completeness of the data, as well as explanations or narrative information provided to discuss any variances, or program interventions. The EQRO reviewed and analyzed the previously submitted reports in order to assess the current state of reporting described by DMMA.

  Toward the end of 2018 and in early 2019, the EQRO began to develop updated reporting templates and guidance to ensure consistent reporting; the EQRO developed standard reporting templates for submission of the reports by both MCOs and refined the technical specifications. The new reporting templates were implemented in April 2019 when Mercer led technical assistance sessions for the use of the required standardized templates, reviewed the technical specifications and each metric within the reporting templates with the MCOs. Throughout the remainder of the year, the EQRO reviewed the quarterly PMs for accuracy and consistency in information and analysis of the data submitted as well as answered ongoing questions from the MCOs.

- Technical assistance with QCMMR. The QCMMR acts as an early alert system to address potential, emerging concerns about the quality, access and timeliness of care management operations of the State-contracted MCOs. As an early alert system, the report relies on self-reported data from the MCOs which is submitted monthly via a secure file transfer protocol site using standardized data-submission templates in Microsoft Excel. When variance in expected results occurs, the MCOs are expected to provide a brief description of the corrective action or steps taken to remediate the variance. The EQRO provides technical assistance to the MCOs to ensure the data submitted to DMMA are complete, accurate and reliable. Trends regarding the data are analyzed quarterly and comparisons are made within each MCO and across MCOs, and when changes in trends are identified, the MCOs are asked to provide a response.

2020 Annual External Quality Review Reporting

During 2020, Delaware's EQRO:

- Prepared and submitted to DMMA the 2019 Annual EQR technical report for the two DSHP MCOs. The annual technical report was submitted to CMS on April 30, 2020.
- Conducted a readiness review of the two DSHP MCOs to ensure they were ready to provide a new adult benefit to members on October 1, 2020.
- Provided technical assistance with QCMMR. The QCMMR acts as an early alert system to address potential, emerging concerns about the quality, access and timeliness of care management operations of the State-contracted MCOs.
- Provided technical assistance on DMMA's Quality Strategy.
- Conducted 2020 external quality review activities, including Information Systems Capabilities Assessments (ISCAs), and began preparation of the 2020 annual technical report.

The EQRO's annual technical report found that the MCOs were deficient in meeting expectations to improve timely access to care, to improve the quality of care, to control the growth of healthcare expenditures while ensuring members are satisfied with services as outlined in the quality strategy (QS). The EQRO noted that the MCOs had shown strong performance in compliance with federal regulations. However, as evidenced by the HEDIS results, both MCOs had room for improvement in timely access to primary and preventive services, access to maternal and pregnancy services, quality of early life and early detection services, quality of weight and nutrition management and diabetes management. While members for one MCO shared a relatively high level of satisfaction with five of the 14 CAHPS adult or child measures, they have opportunity for improvement in the remaining nine measures. The second MCO has significant opportunity to improve member satisfaction in all CAHPS adult and child measures. DMMA continued working collaboratively with the MCOs as they implemented activities towards continuous quality improvement.

2021 Annual External Quality Review Reporting

During 2021, Delaware's EQRO:

- Finalized the 2020 annual EQRO reports on April 1, 2021.
- Provided technical assistance with QCMMR.
- Provided technical assistance on DMMA's Quality Strategy and PM reporting.
- Completed a Maternal Health Focus study at the request of DMMA and produced MCO-specific reports for DMMA.
- Kicked off the National Core Indicators-Aging and Disabilities Survey

- Developed MCO-specific comprehensive EQRO reports. Mercer completed a comprehensive compliance review of the two MCOs that encompassed the three mandatory activities, compliance review, validation of performance measures, and validation of performance improvement projects for both MCOs. Mercer also completed a comprehensive ISCA.

The EQRO's annual technical report concluded that:

- AmeriHealth Caritas Delaware (ACDE) was fully compliant or "Met" all expectations in four of the eleven Subpart D and QAPI standards (provider selection, confidentiality, subcontractual relationships and delegation, and grievance and appeal system) and Highmark Health Options (HHO) was fully compliant in two areas (confidentiality and practice guidelines). However, there were a number of items within the standards needing a corrective action plan. The areas of greatest opportunity for ACDE identified in the compliance review were related to care coordination and utilization management. By contrast, the areas of greatest opportunity for HHO were related to provider network and quality.
- Based upon the ISCA review, ACDE continued to demonstrate effective partnership and collaboration between the local health plan and the enterprise ACFC teams, operations and systems and, as such, continues to perform well in supporting the systems-related requirements of Delaware's managed Medicaid program. The insights gained from ACDE's ISCA desk review and virtual discussions confirmed a strong infrastructure, claims and encounters subject matter expertise, and teamwork and commitment to Delaware.
- HHO demonstrated their continued efforts to improve their claims processing operations to effectively support Delaware's Medicaid managed care program. HHO has made substantial progress in claims remediation activities, as well as identifying and implementing process improvements that improve claims processing outcomes overall. The insights gained from HHO's ISCA desk review and virtual discussions confirmed HHO's efforts to improve the claims operations and underlying infrastructure to ensure accurate claims processing.
- Both ACDE's and HHO's ongoing collaboration with DMMA and Gainwell on identifying and remediating encounter data submission issues has been beneficial to stakeholders. Both MCOs have processes in place to generate standardized PMs (e.g., HEDIS and CAHPS) to fulfill contractual obligations. However, the validation of PM results indicated room for improvement for both MCOs in State-specific reporting.
- There is significant opportunity for improvement in HEDIS results for both MCOs. Of the 36 reported measures for ACDE, one measure, inpatient utilization — surgery average length of stay (ALOS), was at or above the 90th percentile. Seven measures, postpartum care, appropriate treatment for children with upper respiratory infection, inpatient utilization (surgery days/1,000, total inpatient days/1,000), total inpatient ALOS, and mental health (MH) utilization (inpatient services and intensive outpatient and partial hospitalization), were at or above the 75th percentile. Sixteen of ACDE's HEDIS results for these 36 measures (44%) were below the 50th percentile. Of the 36 reported measures for HHO, two measures, timeliness of prenatal care and inpatient

utilization — total inpatient ALOS, were at or above the 90th percentile. Ten measures, well-child visits in the first 30 months of life (15–30 months), inpatient utilization (maternity and surgery ALOS), medicine, surgery and total days/1,000, medicine, surgery and total discharges/1,000, and MH utilization (any services), were at or above the 75th percentile. Fifteen of HHO's HEDIS results for these 36 measures (42%) were below the 50th percentile.

- Through ongoing waiver and grant projects, as well as engagement with the provider community, DMMA supports the efforts of the MCOs to ensure that care is coordinated and managed appropriately with timely access to a stable and robust provider network that is providing high quality care. However, the compliance and HEDIS results represent opportunities for continued collaborative work with the MCOs to achieve Goal 1 (to improve timely access to appropriate care and services for adults and children), and Goal 2 (to improve quality of care and services provided to Medicaid and CHIP enrollees) detailed in the Quality Strategy.
- Both ACDE and HHO improved CAHPS results from 2020 to 2021. ACDE's members gave the highest scoring for the measure All Health Care, which was above the 90th percentile on both the adult and child CAHPS surveys. However, both the adult and child CAHPS surveys highlight a significant opportunity for improvement across Getting Needed Care and Getting Care Quickly measures with ratings falling below the 50th percentile in both categories. HHO's members gave the highest scoring to the Rating of Health Plan measure which was above the 90th percentile on both the adult and child CAHPS surveys. Additionally, adult CAHPS survey respondents gave the highest rating to the Getting Care Quickly measure; and for the child CAHPS survey, respondents gave the highest rating to Rating of Personal Doctor measure. All seven measures for the HHO adult CAHPS survey and four measures for the HHO child CAHPS survey were above the 50th percentile. The child CAHPS survey highlight a significant opportunity for improvement across Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate. These results identify an opportunity for the MCOs and DMMA to work collaboratively toward improving results for the goal of ensuring member satisfaction with services, particularly related to getting needed care and getting care quickly.

B. Ongoing Quality Assurance and Monitoring Activity

As reported in the most recent quarterly and annual reports submitted to CMS, the Delaware Quality Strategy (QS) incorporates quality assurance (QA) monitoring and ongoing quality improvement (QI) processes to coordinate, assess and continually improve the delivery of quality care. The Quality Improvement Initiative (QII) Task Force, whose membership includes a multi-disciplinary statewide group of external contractors and state agencies, participates in oversight and monitoring of quality plans and improvement activities of Medicaid and Title XXI DSHP-funded programs based upon the goals identified in the QS. The QII Task Force assists in monitoring the goals of the DSHP 1115 demonstration.

The QS goals serve as a basis for guiding QII Task Force activities for all Task Force membership. The QII Task Force guiding values and principles are to: seek to achieve excellence through ongoing QII activities; employ a multi-disciplinary approach to identify, measure and access timeliness and quality of care of services to members; hold providers of care accountable; identify collaborative activities; achieve cultural sensitivity; link the community and other advocacy and professional groups; create a forum for communication and open exchange of ideas.

2019 Annual Report on Quality Assurance/Monitoring Activity

- QII Task Force - The QII Task force reviewed Goals 1-3 from the Quality Strategy during the four quarterly meetings in 2019 and reviewed effective strategies as well as barriers and solutions for meeting these goals.
- Case Management Oversight - DMMA oversight staff completed approximately 754 joint visits with the MCOs which included Nursing Facilities and Community based settings. DMMA meets with each MCO quarterly to discuss joint visit findings and collaborates on ways to improve. DMMA case management oversite staff completed onsite file reviews each quarter with Highmark Health Options and AmeriHealth Caritas. DMMA reviewed the findings with each MCO and discussed opportunities for improvement for our Medicaid members.
- DMMA/MCO Meetings - DMMA holds bi-monthly meeting with the two MCOs. These meetings are a forum to discuss issues in a collaborative manner. These meetings are used to collaborate on common practices, identify issues, plan resolutions and establish connections to our sister agencies for coordination of care. Examples of issues covered include: NEMT challenges for members; the transition of Lifespan 1915(c) Waiver enrollees from fee for service to managed care for their state plan services; the new Web Based PASRR System; and post-implementation review of the newly integrated Lifespan 1915(c) waiver population into MCOs.
- Quality Strategy Review - DMMA evaluated the effectiveness of the current Quality Strategy.

2020 Annual Report on Quality Assurance/Monitoring Activity

QII Task Force – In 2020, the QII Taskforce:

- Focused on quality measurement and improvement during COVID-19. The group considered what measures are appropriate during a pandemic, what is scientifically acceptable, the feasibility of calculating the measure given the limitations of COVID-19, and how to implement quality improvement. The group also focused on revisions to the DSHP Quality Management approach. This work involved evaluating DMMA's processes, oversight and monitoring of critical incidents. It also involved a full revision to the Quality Strategy and focusing on the quality improvement process and PIPs;
- Kicked off a comprehensive review and update of our Quality Strategy;
- Actively participated in multiple opportunities for technical assistance and cross-state learning with CMS, Mathematica and AcademyHealth;
- Reviewed the critical incident reporting process;
- Planned for vaccine monitoring strategies and plans in light of COVID-19; and

- Compiled, analyzed and worked on finalizing Delaware's Core Set submission.

Case Management Oversight - DMMA oversight staff completed 2002 telephonic/virtual visits with the MCOs which included Nursing Facilities and Community based settings. Due to COVID-19, DMMA and the MCOs began telephonic/virtual visits in lieu of face to face member visits beginning mid-March 2020. DMMA meets with each MCO quarterly to discuss joint telephonic/virtual member visit findings and collaborates on ways to improve. DMMA case management oversite staff completed quarterly virtual/onsite file reviews with Highmark Health Options and AmeriHealth Caritas. DMMA reviewed the findings with each MCO and discussed opportunities for improvement for our Medicaid members.

DMMA/MCO Meetings - During 2020, DMMA's bi-monthly meetings with the MCOs included topics such as the status of the justice-involved Medicaid member initiative, EVV, the impact of COVID-19 on members, providers and plan operations, and the enrollment of Lifespan 1915(c) Waiver members into managed care.

Quality Strategy Review - DMMA began updating the Quality Strategy.

2021 Annual Report on Quality Assurance/Monitoring Activity

QII Task Force – In 2021, the QII Taskforce:

- Actively participated in multiple opportunities for technical assistance and cross-state learning with CMS, Mathematica and AcademyHealth;
- Focused on best practices for engaging community organizations
- Continued efforts to improve the critical incident reporting process;
- Focused on special topic such as the SUPPORT Act Planning Grant initiatives and the National Diabetes Prevention Program

Case Management Oversight – During 2021, DMMA case management oversite staff completed virtual/onsite file reviews with Highmark Health Options and AmeriHealth Caritas. DMMA reviewed the findings with each MCO and discussed opportunities for improvement for our Medicaid members.

Quality Strategy Review - DMMA continued updating the Quality Strategy.

C. Quality and Care Management Monitoring Report (QCMMR) Activity

The QCMMR reports on the DSHP and CHIP Medicaid Populations while the QCMMR Plus reports on the DSHP Plus population. The QCMMR and QCMMR Plus were developed as a method to specify the metrics to be reported monthly, compare metrics for the two MCO, monitor the results at the State level, and roll up the results quarterly and annually for executive level reporting on the managed care program. The metrics or measures flow from contractual requirements or federal or state regulations contained in the Managed Care program contract.

The DMMA Managed Care Operations unit developed the full circle approach to the QCMMR and QCMMR Plus reporting. The reports are reviewed by the Managed Care Operations team and an agenda is developed for our monthly meeting with each MCO to discuss the findings from the reports. Manage Care Operation's goal is to establish a partnership with the MCOs to improve quality of care for our Medicaid population.

QCMMR Reporting Examples:

- Health Risk Assessment (HRA) Completion Rate: HRAs serve as a key to identifying and engaging members in need of services early in their experience with an MCO. The MCOs are contractually required to complete HRAs with at least 50% of their newly enrolled members within 60 days of enrollment. Health risk assessments are submitted on a 60-day lag and for the 2021 Q4 timeline, both MCOs submitted July, August, September and October data, with ACDE reporting an average rate of 33% completion and HHO reporting an average rate of 48% completion. This is a slight increase from the 2020 Q4 average of a 23% completion rate reported by ACDE and a 34% completion rate reported by HHO. This metric has been a focus within the EQRO review and corrective action plans (CAPs) for both MCOs.
- Customer Service Call Abandon Rate: Both MCOs met the goal for call abandon rate during Q4 and 2021.
- Timely Appointments: For DSHP, MCOs report in alternating quarters on the timely appointments metric. For Q4 2021, the reporting MCO met the goal of 100% access in all of the 20 areas measured related to timely appointments.

Section VII – Estimate of Historical and Proposed Annual Enrollment and Annual Aggregate Expenditures and Financial Analysis of Proposed Changes

A summary of annual and aggregate historical and projected demonstration enrollment and expenditure data is provided in the tables below. Note that not all Medicaid expenditures are captured in these tables. For example, State administrative expenditures and expenditures for populations or services excluded from the current 1115 waiver are not included. Data is limited to expenditures that are considered as part of the current 1115 waiver budget neutrality and projected new expenditures where data and estimates are currently available. Demonstration projections are approximate assumptions for the purposes of the waiver renewal planning. Demonstration financing and budget neutrality assumptions will continue to evolve throughout the course of the waiver renewal process and as new budget data becomes available. The impact and timing of the ending of the PHE will impact enrollment projections. Current impact is shown in DY 28 and beyond.

Table 1. Historical Data for Current DSHP Demonstration Period

	DY24	DY25	DY26	DY27*	DY28*	Five Year Total
	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	
Total Enrollment	205,913	215,034	244,414	260,582	260,582	1,186,526
Total Expenditure (in billions)	$2.085	$2.09	$2.25	$2.32	$2.43	$11.18

*Based on projections from the current approved waiver and pending amendment request. Differences may exist due to rounding.

Table 2. Projected Data for DSHP Demonstration Extension Period

	DY29	DY30	DY31	DY32	DY33	Five Year Total
	CY 2024	CY 2025	CY 2026	CY 2027	CY 2028	
Total Enrollment	266,379	274,434	282,734	291,285	300,096	1,414,928
Total Expenditure (in billions)	$2.62	$2.75	$2.89	$3.04	$3.19	$14.50

Note: Includes amounts from Table 3. Differences may exist due to rounding.

Table 3. Projected Expenditures and Enrollment for New Demonstration Proposals in Renewal Period

	DY29 CY 2024	DY30 CY 2025	DY31 CY 2026	DY32 CY 2027	DY33 CY 2028	Five Year Total
Retroactive Eligibility	NA	NA	NA	NA	NA	NA
Children's Dental Managed Care Expenditures	$59,190,092	$62,149,597	$65,257,077	$68,519,930	$71,945,927	$327,062,623
Members Impacted	114,012	117,433	120,956	124,584	128,322	605,307
Food Box Initiative Expenditures	$1,500,000	$1,575,000	$1,653,750	$1,736,438	$1,823,259	$8,288,447
Members Impacted	1,600	1,680	1,764	1,852	1,945	8,841
Contingency Management Expenditures	$192,900	$289,350	$289,350	$385,800	$385,800	$1,543,200
Members Impacted	100	150	150	200	200	800

Note: All amounts in this table are included in the total expenditures in Table 2. Differences may exist due to rounding.

Section VIII – Interim Evaluation Results and Renewal Evaluation Design

A. Interim Evaluation Results

Per STC #93, an independent external evaluator is tasked with evaluating the demonstration, including data analysis and validation relative to the demonstration hypotheses, the development of quarterly monitoring reports, an interim evaluation report, and a final evaluation report. DMMA commissioned Burns & Associates, a Division of Health Management Associates (HMA-Burns), as the independent external evaluator for the overall evaluation of the DSHP 1115 Waiver and a separate interim evaluation of the SUD component of the DSHP 1115 Waiver. The following is a summary of the two Interim Evaluation reports. A copy of the full Interim Evaluation Reports can be found in Appendix B and on DMMA's website: https://dhss.delaware.gov/dhss/dmma/medicaid.html

1. SUD Interim Evaluation Results

HMA-Burns noted that DMMA saw progress towards our aim to expand SUD-specific services to our Medicaid population through the initial phase of the SUD demonstration period. This occurred through the expansion of coverage for short-term stays in residential and hospital inpatient treatment settings that qualify as institutions for mental disease (IMDs), new services added across the ASAM continuum,

and a concentrated effort to increase access to existing SUD services. The Interim Evaluation concluded that DMMA did not meet all of the desired outcomes outright but still saw many positive impacts due to the DSHP 1115 Waiver. HMA-Burns also noted the PHE likely had a confounding effect in enabling DMMA to fully meet these aims during the demonstration period. When considering the CMS Milestones, DMMA saw success in each milestone with the exception of Milestone 6, Improved Access to Care for Physical Health Conditions Among Beneficiaries.

Among 29 measures reviewed, HMA-Burns found there were 15 where the desired outcome was met. Of these, eight measures had an outcome that was statistically significant in the desired direction. For the 14 measures where the desired outcome was not met, 11 measures had a statistically significant change in the wrong direction. DMMA was also successful in large part in the activities we set out to do in our SUD Implementation Plan. Among the eight activities identified, five were completed in full and the remainder are in progress.

HMA-Burns also identified eight opportunities for improvement for DMMA to consider as we continue to enhance service delivery and access. HMA-Burns' recommendations focus on reimbursement strategies to encourage greater provider participation, education to providers on ASAM criteria and authorization requests, and strategies to incentivize the MCOs to improve initiation and engagement in treatment for SUD beneficiaries.

2. Comprehensive Interim Evaluation Results

HMA-Burns noted that DMMA has seen progress towards our goals related to rebalancing LTC in favor of HCBS, maintaining continuity of enrollment, and maintaining access to care thus far in this demonstration period. The Interim Evaluation concluded that DMMA did not meet all of the desired outcomes outright but still saw many positive impacts due to the DSHP 1115 Waiver. HMA-Burns also noted the PHE likely had a confounding effect in enabling DMMA to fully meet these aims during the demonstration period.

Among the 63 measures, there were 39 measures where the desired outcome was met. Statistical tests were run for 28 of the 63 measures. Among these 28 measures, there are nine measures which have a statistically significant trend in the intended direction, nine measures which have a statistically significant trend in the wrong direction, and 10 measures where the trend was found not to be statistically significant.

HMA-Burns noted the following positive impacts due to the DSHP 1115 Waiver:

Maintaining Continuity of Enrollment
Noteworthy positive impacts were found in the following areas:

- Medicaid enrollment increased over time overall and for most major enrollment categories.

- The percentage of members continuously enrolled has increased for all enrollment

categories examined. For the Medicaid Expansion group, the increase was substantial.

- Enrollment duration in the year also increased across-the-board.

Maintaining Access to Care
Noteworthy positive impacts between CY 2018 and CY 2021 were found in the following areas:

- Increase in the percentage of members ages three to six and among adolescents receiving well-care visits (for adolescents, a statistically significant improvement).

- The rate of postpartum care saw a statistically significant increase from 34.2 percent in CY 2018 to 44.2 percent in CY 2021.

- The rate of emergency department utilization decreased significantly from 65.2 visits per 1,000 in CY 2018 to 49.2 visits per 1,000 in CY 2021.

- Follow-up after an emergency department visit for people with multiple high-risk chronic conditions improved significantly.

- As a percentage of applications received, the rate of enrollment in the PROMISE program increased from 30 percent in CY 2018 to 43 percent in CY 2021.

- The PROMISE provider network also increased from 318 to 377 providers.

Maintaining or Improving Health Outcomes
Noteworthy positive impacts between CY 2018 and CY 2021 were found in the following areas:

- The rate of adherence to antidepressant medication management improved at both the 12 week and six month mark.

- The medication adherence rate, expressed as the proportion of days covered, saw a statistically significant increase among the DSHP Plus population.

- Member grievances and appeals remain very low when measured on a per 1,000 member month basis.

- Among the DSHP Plus population, improvement was seen among all six LTSS CAHPS survey composite measures during the demonstration period thus far. The rate of critical incidents per 1,000 also decreased during the demonstration period.

Rebalancing LTSS in favor of HCBS.
Noteworthy positive impacts between CY 2018 and CY 2021 were found in the following areas:

- The utilization rate of HCBS services among DSHP Plus members.

- The PMPM expenditures for HCBS among DSHP Plus members increased 39 percent while the PMPM expenditures for institutional care decreased 16 percent.

- The proportion of spending between HCBS and institutional care changed from a mix of 25 percent/75 percent in CY 2018 to 35 percent/65 percent in CY 2021.

Areas in which HMA-Burns will focus on assessing improvement in the remainder of this demonstration period include the following:

- Well-child visits in the first 15 months of life
- Breast cancer screenings
- Adults' access to preventive and ambulatory health services
- Access to primary care and dental visits among the former foster care population
- All-cause hospital readmission rates for the DSHP Plus population
- Emergency department visits for the PROMISE population
- Follow-up visits from the emergency department related to alcohol or other drug dependence and for mental health issues for the entire population
- Initiation and engagement rates for alcohol and other drug dependence among the PROMISE population

HMA-Burns also identified eight opportunities for improvement for DMMA to consider during the remainder of the demonstration period which focus on:

1. Developing performance improvement projects (PIPs) specific to improving follow-up after emergency department or hospitalization for mental illness or for alcohol and other drug dependence.

2. Enhancing managed care reporting that will allow for assessing the effectiveness of case management by tying enrollment by the member in case management with specific access or health outcomes.

3. Continuing the rate study of mental health services and considering value-based payment alternatives for providers serving the PROMISE population in particular.

4. Consider including the services specific to the PROMISE program under the responsibility of the MCOs. Or, at minimum, strengthen the oversight of the coordination of care requirements between the MCO's case manager for acute care services and the state's PROMISE care manager for PROMISE services.

B. Proposed Renewal Evaluation Design

Table 1. Proposed Hypotheses and Evaluation

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
1.	DSHP members who participate in the Food Box Initiative for postpartum members will have reduced food insecurity, reduced health disparities and improved health outcomes compared to eligible members who do not participate.	The percentage of participating members who attend postpartum visits and infant well-child visits will increase as compared to members who do not participate in the Food Box initiative. Participating members will report increased food security during the postpartum period impacted by the Food Box Initiative.	CMS Adult, Child and Maternity Core Sets Claims and encounter data New survey (e.g., The Six-Item Short Form of the Food Security Survey Model, USDA)	New
2.	Expanding SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	The percentage of eligible Medicaid beneficiaries who participate in contingency management will increase during the five-year period.	Claims and encounter data	New

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
3.	Expanding SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	The rate of participation in contingency management programs should be relatively similar across racial and ethnic groups, factoring in any underlying differences in substance use across these populations (i.e., contingency management should be promoted to, and ideally utilized by, eligible Medicaid members regardless of race or ethnic background).	Claims and encounter data Medicaid enrollment data	New
4.	Expanding SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	SUD treatment retention rates will increase among eligible individuals who participate in contingency management programs.	Claims and encounter data	New
5.	Expanding SUD/OUD	The rate of negative drug tests will be higher	Claims and encounter data, including	New

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	among individuals with stimulant use disorder who participate in contingency management than among individuals who do not participate in contingency management.	relevant diagnosis codes: R82.998 for a positive urine test, and Z71.51 for a negative urine test)	
7.	Expanding SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	Increasing access to contingency management will reduce emergency department utilization and preventable hospital admissions.	Claims and encounter data	New
8.	Expanding SUD/OUD treatment for eligible Medicaid members with a	Increasing access to contingency management will	Claims and encounter data	New

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	reduce fatal and non-fatal drug overdoses.	DFS death data/toxicology reports	
9.	Expanding SUD/OUD treatment for eligible Medicaid members with a stimulant use disorder and/or opioid use disorder will help improve health outcomes, address health inequities and address the rise in fatal drug overdoses throughout Delaware.	Pregnant people who participate in contingency management will have newborns with lower rates of neonatal abstinence syndrome, when compared to their counterparts who did not participate in contingency management.	Claims and encounter data	New
10.	Dental managed care for children will result in a positive (or no negative) impact on child dental access, health outcomes and	MCOs will maintain access to dentists at or above FFS levels. Parents/caretakers will report satisfaction with	Modified CAHPS Dental Plan Survey Claims, provider enrollment data, reports submitted by MCOs	New

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	parent/caretaker satisfaction.	key access measures of dental managed care.		
11.	Trends observed in access to health care through the DSHP 1115 Waiver for the Medicaid population continue (or does not worsen) in the current waiver period.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
12.	Trends in coordination of care and supports continues (or does not worsen) in the current waiver period	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
13.	Coordination of care and supports maintains or improves quality of care and health outcomes in the current waiver period	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
14.	Trends in consumer satisfaction will continue (or not worsen) in the current waiver period.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
15.	Creating a delivery system that provides incentives for	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	resources to shift from institutions to community-based LTSS has maintained or increased utilization of HCBS services where appropriate in the current waiver period.			
16.	Trends in health outcomes will continue or improve in the current waiver period for individuals enrolled in the PROMISE program	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
17.	The PROMISE program network capacity will continue (or not worsen) in the current waiver period.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
18.	The availability of the adult dental benefit will improve access to dental services and will continue (or not worsen) health outcomes in the current waiver period.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
19.	The demonstration	No change from current approved DSHP 1115 waiver evaluation design, described in		Continuing

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	will increase or maintain the percentage of beneficiaries who are referred and engage in treatment for OUD and other SUDs.	Attachment H of the approved DSHP 1115 Waiver.		
20.	The demonstration will increase or maintain adherence to and retention in treatment for OUD	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
21.	Approved service authorizations improve appropriate utilization of health care services in the post-waiver period	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
22.	The demonstration will decrease the rate of emergency department and inpatient visits within the beneficiary population for SUD.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
23.	The demonstration will increase or maintain the	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	percentage of beneficiaries with SUD who experience care for comorbid conditions			
24.	Among beneficiaries receiving care for SUD, the demonstration will reduce or maintain readmissions to SUD treatment.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
25.	The demonstration will decrease the rate of overdose deaths due to opioids.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
26.	The demonstration will increase or maintain the use of Delaware's PDMP.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
27.	The demonstration will decrease or maintain per beneficiary per month costs.	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
28.	The demonstration will increase or maintain per beneficiary per month costs for SUD services	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	versus non-SUD services.			
29.	The demonstration will decrease or maintain per beneficiary costs for SUD-related ED visits and inpatient stays	No change from current approved DSHP 1115 waiver evaluation design, described in Attachment H of the approved DSHP 1115 Waiver.		Continuing
30.	The addition of two evidence-based home visiting models will improve the health and wellbeing of the Medicaid participants.	No change from the amendment currently under CMS review. DMMA is in the process of defining the evaluation measures, which may include measures such as: Mother Child Depression Screening, post-partum visit, treatment for a behavioral health condition, and dental visit.		New (Pending CMS review of amendment)
31.	The provision of home-delivered meals and nursing facility transition services, as part of an HCBS benefit package, will succeeds in supporting Delaware's goals of improving access to health care by expanding access to HCBS and rebalancing Delaware's long-term care system in favor of HCBS.	No change from the amendment currently under CMS review. DMMA intends to incorporate the addition of a second home delivered meal into the current Evaluation design that assesses whether the provision of meals, as part of a package of HCBS services, succeeds in supporting Delaware's waiver goals. DMMA will also add a measure related to the percentage of reinstitutionalizations lasting more than 30 days, using claims and encounter data, and work with CMS to align DSHP 1115 waiver measures with Money Follows the Person (MFP).		New (Pending CMS review of amendment)
32.	The provision of a respite benefit for caregivers reduces informal	No change from the amendment currently under CMS review. These items will be measured through the administration of a		New (Pending CMS review of amendment)

	Proposed Hypotheses	Methodology	Data Sources	New/Continuing?
	caregiver burnout and increases family/caregiver satisfaction with the program.	family/caregiver survey that will be included as part of the current Evaluation design.		
33.	The provision of a self-directed option for children receiving Medicaid State Plan personal care (attendant care) will increase family satisfaction with this Medicaid benefit and expand the DSP workforce.	No change from the amendment currently under CMS review. Family satisfaction will be measured through the administration of a family/caregiver survey that will be included as part of the current Evaluation design. Additionally, DMMA will add a measure related to the percentage increase in DSP network participation, using MCO provider enrollment data, because of this option.		New (Pending CMS review of amendment)

Section IX – Documentation of Compliance with 1115 Transparency Requirements and Post-Award Forum

See Attachment A for documentation of compliance with the requirements for transparency and public notice.

The initial post-award forum was held on January 14, 2020 and no comments on the waiver progress were received. DMMA posted the date, time and location of the forum on its website 30 days prior to the post-award forum. DSHP is a standing agenda item for each quarterly MCAC meeting and these meetings also serve as the annual post-award forums. Frequent areas for updates and comments on progress include: MCO contracting; managed care enrollment; the DSHP 1115 Waiver July 2022 amendment, and special initiatives (e.g., adult dental implementation, COVID-19 PHE, APRA Section 9817 HCBS Spending Plan and PROMISE).

Section X – Demonstration Administration

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Attachment A – Documentation for 1115 Waiver Transparency Requirements

Reserved for final application to CMS

Attachment B – Interim Evaluation Reports

Reserved for final application to CMS. The interim evaluation report for the overall evaluation of the DSHP 1115 Waiver and a separate interim evaluation of the SUD component of the DSHP 1115 Waiver are posted with the draft DSHP 1115 Waiver application on DMMA's website and summarized in Section VIII.

DMMA's website: https://dhss.delaware.gov/dhss/dmma/medicaid.html